

**The Behavioral Change Clinic, PLLC**  
**with Dominic C. Mocerì, PhD**  
200 East Big Beaver Road, Troy, MI 48083  
Phone: 248.564.1183 | Fax: 248.458.4578  
[www.BehavioralChangeClinic.com](http://www.BehavioralChangeClinic.com)

**ADULT INTAKE FORM**

*If you need more space, you may use additional paper.*

**Demographic Info**

Name: \_\_\_\_\_ | Date Completing Form: \_\_\_\_\_  
Legal Name (if different): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ | Age: \_\_\_\_\_ | Gender: \_\_\_\_\_ | Marital Status: \_\_\_\_\_  
Race/Ethnicity (optional): \_\_\_\_\_ | Spirituality/Religion (optional): \_\_\_\_\_  
Home Address (Street, City, Zip): \_\_\_\_\_  
Names & Ages of People Living Here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone 1: \_\_\_\_\_ (Mobile/Home/Work) | Permission to leave a message  Yes  No  
Phone 2: \_\_\_\_\_ (Mobile/Home/Work) | Permission to leave a message  Yes  No  
Email\*: \_\_\_\_\_ | Permission to leave a message  Yes  No  
Name of Employer and/or School (if any): \_\_\_\_\_  
Occupation: \_\_\_\_\_ | Education Level: \_\_\_\_\_ (Current/Completed)

\* If you use a school/employee email, the school/employer may have a legal right to read the email.  
Please, see "COMMUNICATION POLICY FORM" for additional important privacy information.

**Treatment Targets**

Why are you seeking psychotherapy? What do you want to accomplish in psychotherapy? What are your roadblocks? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did the problem(s) start? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current stressors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your strengths? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your most important values (i.e., What's most important to you)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mental Health History**

**Emotions (0-10):** Please rate the below emotions, where 0 is an absence and 10 is an abundance.

**Happiness:** \_\_\_\_\_ | **Sadness:** \_\_\_\_\_ | **Anxiety/Fear:** \_\_\_\_\_ | **Anger/Outbursts:** \_\_\_\_\_ | **Pain:** \_\_\_\_\_

**Family History:** Please summarize any known/suspected genetic history, including who and what (e.g., depression, anxiety, OCD, Tourette's/tics, ADHD, learning disabilities, alcohol/drugs, suicide, death).

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**Previous Psychotherapy:** Please summarize any previous experience(s), including therapist names, dates, why you started, why you stopped, what you found (un)helpful, etc. \_\_\_\_\_

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**Mind-Body Connection**

**Diagnoses & Medications:** Please list all relevant mental and physical problems.

Diagnosis	Current Provider	Current Medication	Dosage

**Physical Health:**  Excellent  Good  Fair  Poor | **Last Exam by a Medical Professional:** \_\_\_\_\_

**Overall Health:** Please summarize any concerns that you have had (e.g., physical issues; hospitalizations, surgeries; serious accidents, injuries, or seizures; traumatic brain injury; anxiety regarding illnesses, needles, vomit; frustration with not being understood by professionals). \_\_\_\_\_

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**Developmental History:** Please summarize any complications during pregnancy; alcohol, marijuana, or drug use during pregnancy; complications at birth; problems during infancy; and delays in developmental milestones, such as walking and talking. \_\_\_\_\_

**Sleep Hygiene:** Please summarize when you typically go to sleep, when you typically wake up, total hours of sleep, what you do the last hour before going to bed.

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**Exercise:** Please summarize what you do for physical activity, its frequency, and time of day it occurs.

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**Eating:** Please summarize any issues/concerns with dietary restrictions, snacks, overeating, anxiety, etc.

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**Social Environment**

Please summarize the impact of the following on your quality of life (past and present). Include **unique** circumstances and relevant **cultural** attitudes, experiences, and values.

**Family of Origin:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Home &/or Romantic Relationships:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friendships:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Education/School** (e.g., Grades/GPA; Relationships with Teachers & Students; Bullying?; Detentions?; Suspensions?): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Employment/Homemaking:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional Concerns**

Please summarize any concerns that you or anyone close to you have had (past and present) with...

**Trauma History** (e.g., Abuse, Neglect, Accidents): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Legal History** (e.g., substantial tickets; convictions): \_\_\_\_\_  
\_\_\_\_\_

**Substances** (e.g., Alcohol, Marijuana, Drugs, Prescription Medications, Smoking, Vaping): \_\_\_\_\_  
\_\_\_\_\_

**Excessive Behaviors** (e.g., Internet, Video Games, Spending Money, Food, Sex): \_\_\_\_\_  
\_\_\_\_\_

**Safety** (e.g., Self-Injury, Suicidal Thoughts and/or Attempts, Violent Plans and/or Actions): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## COMMUNICATION POLICY FORM

**RESPONDING TO MESSAGES:** Please, allow your Therapist two business days to return your message. If you need a rapid response, please specify this in your message and your Therapist will do their best to accommodate. If your Therapist will be unavailable for an extended period of time (e.g, family medical issue; vacation), you will be notified and provided with contact information for another Therapist, if desired.

**EMERGENCIES:** If you are experiencing an emergency, please dial 988 for the Suicide and Crisis Lifeline; dial 911 for Emergency Assistance; or go to the nearest emergency room. After you have arrived, call the Clinic line (248.564.1183) and sign a Release Form from my Forms webpage to coordinate care.

**PHONE, EMAILS, AND TEXTING:** Mobile phones, emails, and texting are not considered secure methods of communication as information can potentially be intercepted in transit. Messages should be limited to scheduling and sharing important files rather than sharing detailed personal information due to the inherent risks associated with transmitting personal information over the internet and via mobile networks.

- **Texting** is a particularly vulnerable form of communication as messages are typically transmitted and stored without encryption or password protection.
- **Emails** sent from The Clinic will be encrypted in a HIPAA secure manner. If you reply to an encrypted email sent by your Therapist using that program, the message should be encrypted on its trip to the Therapist. If you use a school/employee email, the school/employer may have a legal right to store and read the email.

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*I have read the Communication Policy Form and agree to its terms.*

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**Client Signature**

**Date**

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**Clinician Signature**

**Date**

**Emergency Contact (Mandatory)**

*In the case of an emergency, please provide the following.*

**Emergency Contact Name:** \_\_\_\_\_ | **Relationship:** \_\_\_\_\_

**Emergency Contact Phone Number:** \_\_\_\_\_

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**Client Signature**

**Date**

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**Clinician Signature**

**Date**

## FINANCIAL POLICY FORM

**PAYMENTS:** Payments are expected **at the start** of each session, unless you have a credit card on file (see “*PREAUTHORIZATION FORM*”). The Clinic will provide receipts upon request.

- **TYPES OF PAYMENTS:** The Clinic currently accepts cash, checks, Visa, Mastercard, Discover, American Express, PIN Debit, and Health Savings Account (HSA) transactions. The Clinic may change the payment options at any time. Checks should be made out to “The Behavioral Change Clinic, PLLC.” If any charges are billed to the clinic due to insufficient funds, you will owe the balance to the Clinic. If this happens multiple times, there may be a \$20 surcharge each time.
- **OVERDUE BALANCES:** In the event of a balance being over 30 days overdue, a late fee of 2% will be charged each month. In the event that a balance is over 60 days overdue, The Clinic reserves the right to pursue legal methods to obtain payment, such as using a collection agency or small claims. In such an event, the bare minimum amount of information will be released to obtain payment (which includes at least the Client’s name, contact information, the amount due, and the name of The Clinic). At least three phone calls and three letters across two months will be made by The Clinic before legal methods are employed.
- **ANOTHER PAYER:** If someone else (aka the Payer) is making payments directly to the Clinic for your treatment (e.g., using a credit card for copays, coinsurance, deductible, private pay), the Clinic reserves the right to verify their identity (e.g., photo ID) and to verify that they are consenting to paying, which may include them briefly coming to the Clinic in person once or another non-obtrusive method agreed upon by the Clinic. The Clinic reserves the right to require that a “RELEASE FORM” for this person (aka the Payer) for the sole purposes of discussing payments. Both you (aka the Client) and the Payer will need to sign the “PREAUTHORIZATION FORM” if the Payer is using their credit card.

**INSURANCE:** You are responsible for all deductibles, copays, and/or co-insurances that are outlined in your insurance policy for behavioral health. Any information provided to you by The Clinic is a quote, not a guarantee. If the insurance company refuses to pay for any reason, you will be responsible for the private pay amount outlined below. If required by your insurance company, you are responsible for obtaining a referral (e.g., from your primary care physician or pediatrician). By using insurance and signing this document, you are authorizing the release of information necessary for transactions and assignment of benefits for claims (usually name, date of birth, date of service, procedure code, diagnosis codes, and subscriber’s name and date of birth). If you have both primary and secondary insurance, The Clinic will submit bills according to applicable laws and regulations.

- **IN-NETWORK (IN):** The Clinic and/or your Therapist is currently in-network for the following insurances. The Clinic will bill your insurance company directly if you are in-network.
  - **Aetna:** Active Aetna networks include *First Health/Cofinity* and *Coventry Health Care*.
  - **Blue Cross Blue Shield (BCBS):** The following *BCBS of Michigan (BCBSM)* networks are currently active: *Traditional, PPO TRUST, and Medicare Plus Blue PPO*. Blue Care Network (BCN) is **NOT** an active network and does not usually provide out-of-network benefits.
  - **Medicare:** Michigan Medicare Part B is in-network. However, most Medicare Advantage plans (aka Medicare Part C) are **NOT** active networks and may not provide out-of-network benefits. Medicare Plus Blue PPO (through BCBS) is an exception.
- **OUT-OF-NETWORK (OON):** If your insurance company allows out-of-network benefits AND the reimbursement rates are comparable to the Private Pay rate, The Clinic will attempt to bill your

insurance company. You will still be responsible for any deductibles, copay, or co-insurance, as outlined in your insurance policy for behavioral health. The Clinic will not agree to a Single Case Agreement (SCA) under most circumstances.

**PRIVATE PAY (PP):** If your insurance is not accepted at The Clinic, or your insurance company rejects the bill (and attempts to resolve it were unsuccessful), the below fee schedule applies. The Clinic reserves the right to alter and update the Fee Schedule. Whenever possible, The Clinic will provide you with at least a 90-day advance notice. An absolute minimum of 30-days will be provided before any fee increases. Review of the fee schedule will likely occur at least annually.

**MISSED APPOINTMENTS:** Missed appointments include both failing to show up for a scheduled appointment (i.e., No Show) as well as cancelling or rescheduling with less than 24 hours (as determined by the time stamp of the voicemail or email). Insurance will not pay for any part of this fee, and you will be charged the full amount listed in the fee schedule below for a full session.

- *On a case by case basis, the missed appointment fee may be **waived** under extenuating circumstances (e.g., contagious illness; medical emergency; flat tire; your work shift being rescheduled against your will; an adult having to stay home with a sick child; significant weather advisory/warning/watch). Notes (“proof”) will NOT be required. If this occurs frequently, this will be discussed, and the fee is unlikely to be waived for the following incident(s).*
- *Fees will **not be waived** for preventable circumstances (e.g., forgetting another medical appointment was scheduled at that time; a child having homework, a project, or a quiz/test the next day; normal traffic; lack of coordination of automobiles with another household member).*

**FEE SCHEDULE:** This table provides the standard fees for the Clinic.

<b>PSYCHOTHERAPY SERVICES</b>	<b>CPT Code</b>	<b>Fee</b>
<b>*Initial Evaluation (first appointment)</b>	<b>90791</b>	<b>\$250</b>
<b>*Full Session (53-60 minutes)</b>	<b>90837</b>	<b>\$210</b>
Three-Quarter Session (38-52 minutes)	90834	\$175
Half-Session (16-37 minutes)	90832	\$125
Family Session with Client Present (26-60 minutes)	90847	\$210
<b>*Parent/Family Session without Client Present (26-60 minutes)</b>	<b>90846</b>	<b>\$210</b>
Crisis Session (30-74 minutes)	90839	\$250
Additional Time for Crisis (per additional 30 minutes above 60 minutes)	90840	\$150
Intensive ERP per hour (may not be covered through insurance)		\$210
<b>OTHER FEES<sup>1</sup></b>		
<b>*Forms &amp; Letters (per 15 minutes)</b>	<b>N/A</b>	<b>\$50</b>
<b>*Missed Appointments</b> (No Shows; Cancelling or Rescheduling with less than 24-hours per the voicemail or email timestamp)	<b>N/A</b>	<b>\$210</b>
Travel Time to non-Clinic sites		
First 30 minutes (minimum)	N/A	\$125
Each additional 15 minutes	N/A	\$50

\* Most common billing codes used at The Clinic.

<sup>1</sup> "OTHER FEES" are not reimbursable by insurance and are separate from intake/session deductibles, coinsurance, and copays. Short phone calls, short emails, and brief letters (e.g., early dismissal from school) have no fees. Long phone calls may be billed to insurance as a session, if allowed, or charged a prorated private pay fee. Long emails, longer letters, and detailed forms (e.g., disability letter for university accommodations) are subject to prorated fees in 15-minute units. Phone/email should not be used as a replacement for therapy sessions or parent sessions.

**COURT APPEARANCES:** In general, The Clinic discourages involving The Clinic and your therapist in court appearances and testimonies. Complicated ethical and legal issues often arise regarding the confidentiality of treatment that are often unforeseen (see "NOTICE OF PRIVACY PRACTICES & HIPAA INFORMATION FORM"). As the law views fact witnesses and expert witnesses as distinct entities, your Therapist may be restricted in what can be said (e.g., diagnosis, course of treatment, and progress) and unable to provide the testimony that you desire (e.g., make custody recommendations; testifying that a divorce or work situation harmed you). If you believe special circumstance applies and the risks are worth it, you are encouraged to discuss the issue with your Therapist directly in advance. If you decide to proceed, you will be charged for eight times the full session rate plus travel time (as outlined in the "FEE SCHEDULE") for each day of court. This is due to court appearances often requiring the Therapist to cancel an entire day of sessions in addition to preparation time. Additional fees might apply.

**WAIVER OF JURY TRIAL (LANDLORD):** According to the lease of The Behavioral Change Clinic, PLLC, all clients, family members, guests, and invitees are bound by the following agreement. By signing this document you are waiving your right to a trial by jury of any action or equity brought against the Landlord (i.e., AmeriCenter of Troy, LP) or Landlord's agents or employees, arising out of, or in any way connected to its premises.

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*I have read the Financial Policy Form and agree to its terms. If I am using insurance, I authorize the release of information necessary for transactions and assignment of benefits for claims. If I miss a session or cancel with less than 24-hours notification, I understand that I will be charged the full amount of the session (e.g., copay and what insurance typically pays) and that insurance will not pay for this. I understand that knowingly providing false or misleading information for payments (private or insurance) may be subject to criminal and civil penalties. If any part of this agreement is deemed unenforceable, then that part shall be omitted but such omission will not affect the rest of the agreement herein.*

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**Client Signature**

**Date**

**Clinician Signature**

**Date**

**Insurance Information**

If you are using insurance to pay for any portion of treatment, please complete the below information.

**Insurance Company:** \_\_\_\_\_ **State Insurance is Purchased (e.g., MI):** \_\_\_\_\_  
**Enrollee/Member ID:** \_\_\_\_\_ | **Group Plan ID:** \_\_\_\_\_  
**Subscriber's Name:** \_\_\_\_\_ | **Subscriber's Date of Birth:** \_\_\_\_\_  
**Subscriber's Home Address (If different from Client):** \_\_\_\_\_  
**Subscribed Through (e.g., Subscriber's Employer):** \_\_\_\_\_

## PREAUTHORIZATION FORM

As a courtesy The Clinic accepts automatic payments for those who keep a payment number on file. The clinic currently accepts cash, checks, Visa, Mastercard, Discover, American Express, PIN Debit, Health Savings Account (HSA) transactions, and Flexible Spending Account (FSA) transactions. The Clinic may change the payment type that it accepts at any time, in which case another payment type must be used.

**CHARGES:** Automatic payments on file will be billed sometime between the end of that session and 30 days thereafter, whenever possible. The **full balance due** will be charged at that time.

**EXTRA PRIVACY AND SECURITY:** If you should desire extra privacy and security, you may put a card on file two additional ways. **One**, you may write “\*\*\*\* [insert last 4 digits] given during [insert date] session” on the “Credit Card Number Line.” You will then provide your Therapist with the number during that session, who will manually enter it in the system. **Two**, you may write “Activate my TherapyPortal.” You will be then be sent a message to your primary email on file, where you will be asked to enter the information online securely. After you sign the online form, the credit card number will be redacted from the view of The Clinic and your Therapist, except for the last four digits. **If you choose either of these options, you must still sign and complete the remainder this form.**

**HSA/FSA LIMITATIONS:** HSA and FSA can only be charged for psychotherapy services provided. They **cannot** be charged for missed appointments or other fees arranged with The Clinic. If you put an HSA/FSA card on file, please complete a **second version** of this form, which will be used if/when your HSS/FSA is ineligible (e.g., too low of a balance; fees).

**Client’s Legal Name:** \_\_\_\_\_  
**Name of Individual on Credit Card:** \_\_\_\_\_  
**Relationship to Client (Self/Parent/Guardian/Spouse/Other):** \_\_\_\_\_  
**Credit Card Number:** \_\_\_\_\_  
**Card Security Code (CSC):** \_\_\_\_\_ | **Expiration Date:** \_\_\_\_\_  
**Type of Card:**  Credit Card  Debit Card  HSA Card  FSA Card  
**Billing Address of Cardholder (Street, City, Zip):** \_\_\_\_\_  
**Billing Phone Number of Cardholder:** \_\_\_\_\_ (Mobile/Home/Work) |  
**Permission to leave a message**  Yes  No

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*I have read the Preauthorization Form and agree to its terms. The full balance due will be charged. If I miss a session or cancel with less than 24-hours notification, I understand that I will be charged the full amount of the session (e.g., copay and what insurance typically pays) and that insurance will not pay for this. I understand that knowingly providing false or misleading information for payments (private or insurance) may be subject to criminal and civil penalties.*

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<b>Client Signature</b>	<b>Date</b>	<b>Clinician Signature</b>	<b>Date</b>
_____	_____	_____	_____

  

<b>Cardholder’s Signature</b>	<b>Date</b>
_____	_____

*(necessary if different from Client Signature)*



## INITIATING TREATMENT FORM

**Your Choice:** You are consenting to begin assessment and/or treatment at The Behavioral Change Clinic, PLLC. You will be expected to be an active participant throughout the psychotherapeutic process, including identifying challenges, setting goals/objectives, and making concrete changes in your life. Your Therapist can help you with this process. You are encouraged to ask your Therapist questions and are able to revise your goals/objectives throughout treatment.

**Behavioral Tasks:** You will very likely be asked to attempt **behavioral tasks during and between sessions**. You might initially think that these tasks are daunting or anxiety-provoking, but your Therapist will work with you to accomplish these tasks step by step. You will never be asked to do something against your will or something that is actually dangerous. You will always have a choice.

**Regular Attendance:** In order to make meaningful progress in psychotherapy, most people require weekly psychotherapy appointments. In order to help prevent irregular attendance, you will likely be assigned an ongoing appointment time (e.g., Wednesdays at 3pm) that you are expected to attend each week (except for unusual events, such as illnesses or Holiday vacations). If you reduce the frequency of attendance due to improvement, you may be asked to change the day/time to a timeslot where another person is alternating their weeks.

- In order to be fair to the many people still seeking treatment, The Clinic has established the following policies:
- **Irregular Attendance:** If your attendance is irregular, The Clinic may assign that timeslot to another person. Your new timeslot may be at a different time of day and/or a different day of the week. If irregular attendance becomes a concern, your Therapist will discuss this with you. Missing four ongoing appointment times in a row automatically counts as irregular attendance.
- **Default Closing:** If you do not attend a session for six weeks, The Clinic may close your chart. Under special circumstances (e.g., visiting relatives in another country; surgery), exceptions can be made if they are discussed with and agreed by your Therapist. Your chart can be reopened if you call your Therapist and your Therapist agrees; but there is no guarantee that your previous ongoing appointment time will still be available. If you are planning on terminating treatment, you should discuss this with your Therapist in advance rather than enact this policy.

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*I have read the Initiating Treatment Form and agree to its terms. I have been given opportunities to ask questions and help design my treatment plan. And, I reserve the right to do so at any time in the future.*

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**Client Signature**

**Date**

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**Clinician Signature**

**Date**

## AUTOMATIC APPOINTMENT REMINDER FORM

As a courtesy The Clinic offers the **option** to enroll you in automatic appointment reminders via text and/or email. There is no charge to you. You may opt-out at any time by following the instructions provided by the practice management software or by notifying your Therapist in writing.

**TIME FRAME:** Text (SMS) messages to mobile devices are typically sent 2-28 hours in advance. Emails are typically sent 24-60 hours in advance.

**RECIPIENTS:** You may list mobile phone numbers or emails for yourself and/or others. The Clinic reserves the right to require that a "RELEASE FORM" is signed for anyone besides yourself for the sole purposes of discussing appointment attendance and reminders. The Clinic reserves the right to limit the recipients, if deemed clinically important.

**DISCLAIMERS:** The automatic reminders are sent by the Clinic's practice management software (which is currently "TherapyNotes," and may be changed at any time with or without notification). The Behavioral Change Clinic, PLLC and your Therapist hold zero liability for the security and privacy of the sending and storage of these messages. See "COMMUNICATION POLICY FORM" for important privacy information about texting and emails. **If you use a school/employee email and/or phone number, the school/employer may have a legal right to store and read the email and/or text message.** If for whatever reason, the automatic reminders are not sent, **you are still responsible** for attending your session. See "FINANCIAL POLICY FORM" and "INITIATING TREATMENT FORM" for details.

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*I have read the Automatic Appointment Reminder Form and agree to its terms. I understand that this form is completely optional and that includes certain benefits and risks. I understand that I may list zero, one, or multiple phone numbers and/or emails.*

**Mobile Phone Numbers (if any):** \_\_\_\_\_  
\_\_\_\_\_

**Emails (if any):** \_\_\_\_\_  
\_\_\_\_\_

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Client Signature

Date

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Clinician Signature

Date

## **NOTICE OF PRIVACY PRACTICES & HIPAA INFORMATION FORM**

**CONFIDENTIALITY:** The Behavioral Change Clinic, PLLC is committed to safeguarding your information regarding your physical health, mental health, and personal history. The Clinic keeps records of your services in order to provide you with quality care, meet ethical guidelines, comply with legal requirements. Federal and state laws, such as HIPAA, protect your right to privacy between a client (aka patient) and Therapist (aka psychotherapist, clinician, behavioral health provider). The Therapist is prohibited from sharing protected health information (PHI) about you with others, unless certain circumstances are met. If you ever have any concerns about your privacy or safety, please express them to The Clinic as soon as possible, so that your concerns can be addressed as soon as possible.

**RISK TO SELF:** If the Therapist assesses that the client is an imminent danger to oneself, hospitalization of the client may be required. Additionally, family members or others may need to become involved to help ensure safety.

**RISK TO OTHERS:** If the Therapist assesses that the client is an imminent danger to the health or safety of another, the law requires that protective actions are taken, such as hospitalization, calling the police, and/or warning the potential victim.

**ABUSE/NEGLECT OF PROTECTED POPULATIONS:** If the Therapist has reasonable suspicion that a member of a special population is being abused or neglected, the law requires that a report is filed with the appropriate agency. Additional actions may be required to ensure safety of the person. Special populations include children under 18, disabled adults, and the elderly.

**OTHERWISE REQUIRED BY LAW:** If the law requires information to be released, then the Therapist will comply with the law to the extent necessary. The Therapist will make efforts to protect sensitive information as much as legally and ethically possible. These situations are usually rare, but often involve court cases. Please be aware that releasing any information about your treatment in a courtroom (such as a letter) may trigger a process that allows your entire record to be admissible in court. If you suspect that your records may be subpoenaed, please consult with a legal expert who is familiar with HIPAA and psychotherapy laws.

**SIGNED RELEASE FORM:** If you sign a release form, your Therapist receives legal authorization to coordinate your care with whoever is designated on the form. Release forms are often used to allow communication with physicians, psychiatrists, previous psychotherapists, school counselors, teachers, significant others, or family members. However, they can be written to authorize communication to anyone you believe would be beneficial. There typically are no fees associated with your Therapist communicating with the person designated on the release form, unless otherwise discussed ahead of time. The type of information to be shared will be discussed when you sign the form. Release forms can be revoked at any time in writing, which is effective as soon as the communication is received by your Therapist.

At the behest of some insurance companies, your **Therapist requests that you grant permission** for your Therapist to communicate **with (a) your primary medical practitioner (PCP) and (b) other behavioral health specialists (e.g., psychiatrist)**. If you consent, please complete a "Release Form" for each provider. If you choose to complete the form(s), you may limit the type of information to be shared by

## The Behavioral Change Clinic, PLLC

200 East Big Beaver Road, Troy, MI 48083; 248.564.1183

selecting or skipping the options provided. When your Therapist can openly communicate with your psychiatric medication prescriber (if applicable), both treatments are often enhanced. However, you **may decline** to submit a “Release Form” for any reason without your treatment at The Clinic being limited under the vast majority of circumstances.

**INSURANCE INFO SHARED:** By using insurance and signing this document, you are authorizing the release of information necessary for transactions and assignment of benefits for claims (usually name, date of birth, date of service, procedure code, diagnosis codes, and subscriber’s name and date of birth). The insurance company is not usually informed about the details of your diagnosis(es) or personal history. However, the insurance company reserves the right to audit your file (e.g., to investigate insurance fraud). Historically, insurance audits have been rare. If you are concerned about this, you may contact your insurance company, discuss it with your Therapist, and/or sign a form indicating that you are voluntarily choosing to pay privately. You may choose whatever option is best for you, but the vast majority of in-network clients use their insurance.

**PUBLIC SPACES:** Like many clinics, The Behavioral Change Clinic, PLLC is currently located in a building with several other businesses. In order to secure your attention, your name may be used in public areas (e.g., the waiting room and hallways); but your Therapist will not initiate conversations about your private information in these public spaces. If a manager or front desk staff of the building interact with you or your family, you may simply state that you are waiting to meet your Therapist, and they will respect your privacy. Likewise, The Clinic strongly requests that you respect other clients’ privacy if you happen to see someone in a public area.

**SOCIAL MEDIA POLICY:** Social media interactions with your Therapist or The Clinic are prohibited. Social media does not meet ethical and legal guidelines for confidentiality and privacy. Additionally, it introduces elements of multiple relationships (aka dual relationships), which can interfere with current and future assessment and treatment. Neither your Therapist nor The Clinic will accept or respond to messages or contact requests from current, former, or prospective clients (or family members) on any social networking sites (e.g., Facebook, LinkedIn). The Clinic encourages caution with allowing your social media websites and apps to upload your contacts lists, as you may accidentally send a friend/contact message or invite. If you have questions about this policy, please address them with your Therapist.

**CONSUMER REVIEW SITES:** Therapists and Staff of the Clinic will not solicit or request testimonials or consumer reviews. The Clinic does not have any ownership or relationship with review sites for professionals (e.g., Healthgrades, WebMD, Yelp). The Clinic discourages leaving consumer reviews online as it will likely compromise your confidentiality. Instead, you are strongly encouraged to attempt to resolve any complaints or concerns with your Therapist directly.

**BUSINESS ASSOCIATES:** The Clinic contracts with several third-party business associates for services. Current examples include website hosting; digital communication (i.e., email, phone, and fax); electronic health records (EHR); and credit card billing. A signed Business Associate Agreements (BAA) that is HIPAA compliant is obtained whenever PHI is involved (e.g., digital communication; EHR) and other privacy methods are secured for non-PHI business activities. These BAAs and other methods legally protect your personal and medical (mental and physical) information. Your information will never be sold for marketing purposes.

**HIPAA RIGHTS:** The Health Insurance Portability and Accountability Act (HIPAA) provides you with six fundamental rights. You have the right

**The Behavioral Change Clinic, PLLC**

200 East Big Beaver Road, Troy, MI 48083; 248.564.1183

1. to receive a notice about your privacy policies (i.e., this form);
2. to access the medical information The Clinic maintains about you;
3. to limit the uses and disclosure of medical information;
4. to request amendments to the medical record;
5. to revoke or limit authorization; and
6. to an accounting of disclosures of PHI.

Any requests to view or amend your records must be made in writing. A fee may be charged to cover expenses for copying, printing, mailing, or any other activities that require direct costs. Under limited circumstances, requests about your records can be denied. At your written request, the denial can be appealed and reviewed by an independent Therapist chosen by The Clinic. **You are strongly encouraged to attempt to resolve any complaints or concerns with your Therapist directly.** Concerns and dissatisfaction can be resolved verbally but all official complaints must be submitted in writing. If the situation cannot be resolved in a satisfactory manner, you may contact the HIPAA Privacy Officer at “Risk Management 2100 Pontiac Lake Road, Waterford, MI 48328, Phone: 248-858-1000” and ask to speak with the Rights Officer of the Day. **You will not be penalized or retaliated against for filing a complaint.** Additional guidance materials about your rights under HIPAA can be found on the website of the U.S. Department of Health & Human Services: <https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>

**RIGHT TO PAPER COPIES:** If you make a written request, The Clinic will provide you with any signed documents that you have completed.

**CHANGES TO THIS NOTICE & POLICIES:** The Clinic reserves the right to revise and update the Privacy Notice and all other documentation. You will be updated of any changes to policies that substantially affect you. The Clinic will notify you and obtain your signature before implementing any changes to fees.

*I have read the Notice of Privacy Practices & HIPAA Information Form and agree to its terms.*

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Clinician Signature**

\_\_\_\_\_  
**Date**

## REFERRAL SOURCE FORM

Please, check the box that best indicates how you discovered The Clinic or your Therapist. Then, list the name of the person or organization that led you to The Clinic on the line below. Please, do not list the name if the person was another client/patient.

- [www.IOCDF.org](http://www.IOCDF.org)
- Internet Search (e.g., Google)
- a psychotherapist/clinician (e.g., PhD, MA, MSW, LMFT, LPC)
- a psychiatrist (e.g., MD, DO)
- another medical professional (e.g., physician, pediatrician, nurse, internist)
- a school professional (e.g., teacher, school counselor)
- another client/patient (do NOT list a name below)
- Other (Please, specify below)

**Name of Person/Organization:** \_\_\_\_\_

**Address of Person/Organization:** \_\_\_\_\_

**Phone of Person/Organization:** \_\_\_\_\_